

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-021762

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5454

STATE FILE NUMBER

FILED JUN 3 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Infirmary		d. STREET ADDRESS (If outside, give location) 5181 Vernon Avenue	
3. NAME OF DECEASED (Type or print) First Hilda Middle G. Last JOHNSON		4. DATE OF DEATH Month May Day 20 Year 1963	
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/14/09
9. AGE (last birthday) 53	10. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and state or country) Cadiz, Kentucky
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Felbert Curlin	
14. MOTHER'S MAIDEN NAME Lottie Wharton		15. NAME OF HUSBAND OR WIFE Chas. Johnson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of) No		17. INFORMANT Chas. Johnson, 5181 Vernon Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease with Acute Congestive Heart Failure " DUE TO (b) 2) Miliary Tuberculosis (Pulmonary) " DUE TO (c) 0021 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) -	
20c. TIME OF INJURY Hour - a.m. - p.m. -	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		20f. CITY, TOWN, OR LOCATION -	
21. attended the deceased from 5/10/63 to 5/20/63 and last saw her him alive on 5/19/63		22. SIGNATURE (Degree or title) M. D. 3167 Sheridan Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5/24/63	
23c. NAME OF CEMETERY OR CREMATORY Cadiz, Kentucky		23d. LOCATION (City, town, or county) Hopkinsville, Kentucky	
24. FUNERAL DIRECTOR Cunningham & Moore, 2405 Marcus		25. DATE RECD. BY LOCAL REG. MAY 22 1963	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.		22c. DATE SIGNED 5/21/63	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer.

Signed John K Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.